

# State Health Benefits Program Enrollment Form For Retirees, Survivors and LTD Participants

**Instructions for completing this form.** Open Enrollment elections require completing Parts A, B, D and E.

## Part A. Enrollee Information – (Retiree, Survivor or LTD Participant Information Only – Not Family Member Information)

☐ Check here if this is an address change. Social Security Number \_\_\_\_\_

Print Name \_\_\_\_\_ Health Plan Identification Number \_\_\_\_\_  
(First) (M.I.) (Last)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip + 4 \_\_\_\_\_

Day Time Phone (\_\_\_\_\_) \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: ☐ Male ☐ Female E-mail Address \_\_\_\_\_  
Month Day Year

### REASON FORM IS BEING SUBMITTED (Check each appropriate category)

- ☐ **Initial Enrollment.** Check one: ☐ Retirement ☐ VSDP LTD initial enrollment/waiver or other LTD initial enrollment  
☐ Survivor Enrollment ☐ Re-enrolling from family member status in active/other retiree coverage or from other active eligibility  
(Date losing other coverage \_\_\_\_\_)
- ☐ **Now Eligible For Medicare.** ☐ Retiree/Survivor ☐ Spouse ☐ Child ☐ VSDP or other LTD Participant
- ☐ **Open Enrollment (available to Non-Medicare Participants Only) To Change Plans And/Or Membership.**  
☐ Enrollee/Enrollee and Family members ☐ Family member with Separate Coverage
- ☐ **Remove Family member(s) From My Coverage.** (Change will be effective the first day of the month after this form is received.)  
Name of Family member(s) \_\_\_\_\_ Social Security or ID Number \_\_\_\_\_  
If you are removing a family member due to a qualifying mid-year event, please indicate the event below.
- ☐ **Medicare Eligible Member Making Allowable Plan Change.** (Effective date will be the first of the month after this form is received.)  
☐ Retiree/Survivor ☐ Spouse ☐ Child ☐ VSDP or other LTD Participant
- ☐ **Cancel/Waive Coverage (go to Part F.).**
- ☐ **Qualifying Mid-Year Event.** Check the type of event below, and attach the appropriate supporting information as indicated. Please complete participant information in Part B. Submit this change within 60 days of the event. In most cases, the change will be effective the first day of the month following receipt of this form. HIPAA Special Enrollments\* allow the addition of all eligible family members.  
(Event if applicable/Attach This Information) **Date of Event** \_\_\_\_\_

#### Events That Are Consistent With Increasing Membership\*\*

- ☐ Marriage/Marriage Certificate\*
- ☐ Birth or Adoption/Birth Certificate or Adoption Agreement\*
- ☐ Eligible family member loses eligibility for Medicare, Medicaid or other government plan/Government Documentation
- ☐ Spouse or eligible child loses employer eligibility/  
Employer Documentation
- ☐ Judgment, decree or order requiring coverage of an eligible child/Court Order
- ☐ Permanent custody granted/Court Order
- ☐ Spouse's, eligible child's or LTD participant's open enrollment or significant change under another employer's plan resulting in termination of coverage/Employer Documentation to Support Change
- ☐ Other HIPAA Special Enrollment \*
- \_\_\_ LTD Participant or family member loses coverage for which they declined enrollment in this plan
- \_\_\_ Family member loses coverage in Medicaid or the State Children's Health Insurance Program (CHIP)
- \_\_\_ Family member becomes eligible for a Medicaid or CHIP premium assistance subsidy

#### Events That Are Consistent With Decreasing Membership

Retiree group participants can reduce membership prospectively at any time, with or without the events described below. Some of these events may allow enrollment in Extended Coverage.

- ☐ Divorce/Divorce Decree
- ☐ Death of spouse or child/Death Certificate
- ☐ Child loses eligibility/Documentation to Support
- ☐ Judgment, decree or order to remove child/Court Order
- ☐ Covered family member gains eligibility for Medicare or Medicaid/Government Documentation
- ☐ Spouse or covered child gains employer eligibility/  
Employer Documentation
- ☐ Spouse or covered child's open enrollment or significant change under another employer's plan resulting in eligibility for coverage/Employer Documentation to Support Change
- ☐ Enrollment in Marketplace Exchange Health Plan

#### Allows Plan Change

- ☐ Move affecting eligibility for Health Care Plan/Benefits Administrator Validates Move

\*\* You must provide documentation to support a membership addition. Your Benefits Administrator can provide additional information.

TYPE OF MEMBERSHIP

Please select the membership type which describes the membership level for which you are enrolling:

- ☐ Single Coverage      ☐ Two people      ☐ Family – Enrollee with Two or More Family Members

VSDP/LTD Waive or Cancel for existing participants (See Part F. for new participants.):

- ☐ VSDP/LTD Waiver of Health Coverage due to Open Enrollment, or a Qualifying Mid-Year Event (indicate event on page 2)  
☐ VSDP/LTD Cancellation of Coverage without Open Enrollment or a Qualifying Mid-Year Event

Part B. Enrollment

List all Medicare and Non-Medicare participants. Include yourself and everyone you are enrolling in a health plan (including all participants, not just additions or changes). Attach a copy of Medicare cards for all members who are Medicare-eligible.

Relationship Codes: E = Retiree, LTD or Survivor    SF = Spouse female    SM = Spouse male    S = Son    D = Daughter  
SS = Stepson    SD = Stepdaughter    OF = Other female child    OM = Other male child

NAME	Birthday MM/DD/YYYY	Social Security Number	Relationship Code	Medicare Information (if applicable)		
				Medicare Claim No.	Part A Effective Date	Part B Effective Date

HEALTH BENEFITS PLAN SELECTION

Enrollees must select a plan based on their and their family members' Medicare eligibility. Participants who are eligible for Medicare, regardless of age, must select a plan in Part C, and those who are not eligible for Medicare must select a plan in Part D. Enrollment in a Medicare-coordinating (Medicare is primary) plan must take place immediately upon any participant's eligibility for Medicare. If you are making a plan change, you will only receive new ID cards that require updated information.

Part C. Plans For Retiree Group Participants Eligible For Medicare

If you are eligible for Medicare and have not enrolled in both Hospital Part A and Medical Part B of Medicare, contact your local Social Security Administration office. If you enroll in a plan that includes prescription drug coverage, you will be enrolled in Medicare Part D (pending approval by Medicare.) If you enroll in a Medicare Part D plan outside of the state program, you will be moved to Medical-Only coverage and may not return to the state program's Medicare Part D plan.

Please select a plan below and indicate whether the coverage is for you or a family member.

PLAN	COVERAGE FOR (check all that apply)				
<input type="checkbox"/> Advantage 65 (A65)	<input type="checkbox"/> Retiree/Survivor	<input type="checkbox"/> VSDP or other LTD	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	
<input type="checkbox"/> Advantage 65 with Dental/Vision (65DV)	<input type="checkbox"/> Retiree/Survivor	<input type="checkbox"/> VSDP or other LTD	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	
<input type="checkbox"/> Advantage 65 – Medical Only* (65MO)	<input type="checkbox"/> Retiree/Survivor	<input type="checkbox"/> VSDP or other LTD	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	
<input type="checkbox"/> Advantage 65 – Medical Only* with Dental/Vision (MODV)	<input type="checkbox"/> Retiree/Survivor	<input type="checkbox"/> VSDP or other LTD	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	

\* Does not include coverage for outpatient prescription drugs.

The plans below may be selected only by members currently enrolled in an Option II/Medicare Supplemental plan.

PLAN	COVERAGE FOR (check all that apply)		
<input type="checkbox"/> Option II (B2)	<input type="checkbox"/> Retiree/Survivor	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
<input type="checkbox"/> Option II with Dental/Vision (B2DV)	<input type="checkbox"/> Retiree/Survivor	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child

Dental/Vision coverage may be added to either Advantage 65, Advantage 65 – Medical Only, or Option II at any time, and it may be cancelled at any time. However, once the Dental/Vision option has been elected and cancelled one time in any Medicare-coordinating plan, it may not be elected again. Participants in Option II may enroll in Advantage 65 (including Advantage 65 – Medical Only) at any time. However, once enrolled in any Advantage 65 plan, Option II may not be elected again. Except for initial enrollment in a Medicare-coordinating plan, these elections/changes are effective the first of the month following receipt of your request.

## Part D. Plans For Retiree Group Participants Not Eligible For Medicare

All non-Medicare family members must enroll in the same plan.

STATEWIDE HEALTH PLANS	
<input type="checkbox"/> COVA Care (with preventive dental) (ACC0)	<input type="checkbox"/> COVA HealthAware (with preventive dental) (CHA)
<input type="checkbox"/> COVA Care + Out of Network (ACC1)	<input type="checkbox"/> COVA HealthAware + Expanded Dental (CHA2)
<input type="checkbox"/> COVA Care + Expanded Dental (ACC2)	<input type="checkbox"/> COVA HealthAware + Expanded Dental & Vision (CHA1)
<input type="checkbox"/> COVA Care + Out of Network and Expanded Dental (ACC3)	<input type="checkbox"/> COVA HDHP - High Deductible Plan (with preventive dental) (CHD)
<input type="checkbox"/> COVA Care + Expanded Dental + Vision & Hearing (ACC4)	<input type="checkbox"/> COVA HDHP - High Deductible Plan + Expanded Dental (CHD1)
<input type="checkbox"/> COVA Care + Out of Network + Expanded Dental + Vision & Hearing (ACC5)	<input type="checkbox"/> TRICARE Supplement (TRC) DEERS # _____ (required)
REGIONAL HEALTH PLAN	
<input type="checkbox"/> Kaiser Permanente HMO- available in Northern Virginia, Central Virginia and Northern Neck designated zip codes (KP)	

## Part E. Authorization, Enrollee Statement, And Certification

**ENROLLEE STATEMENT:** I want to enroll or make an allowable change in the Retiree Health Benefits Program. The cost of coverage will be deducted from my Virginia Retirement System (VRS) retirement benefit. If I am not receiving a VRS monthly benefit, or if my VRS monthly benefit will not accommodate my health insurance premium, I will be billed directly. To cancel coverage, I must send my request in writing to the appropriate recipient noted on page 5. Cancellation of coverage will be effective the end of the month in which my written request is received. I understand that notice of cancellation does not relieve me from payment for monthly coverage that has already begun. I understand that if I cancel my state retiree coverage, I will not have another opportunity to enroll in the Retiree Health Benefits Program, and that cancellation of prescription drug and/or Dental/Vision benefits will preclude any future enrollment for those benefits. I understand that my health premiums are subject to change. I am aware that the Commonwealth of Virginia reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that failure to pay premiums by the date designated on my monthly bill, if applicable, will result in cancellation of coverage and will permanently revoke my eligibility for the program. Further, I understand that claims may not be processed for services during months for which premium payment in full has not been received. I understand that enrolling or maintaining coverage for ineligible family members may result in removal from the State Retiree Health Benefits Program for up to three years.

**CERTIFICATION/AUTHORIZATION:** I certify that I understand the State Retiree Health Benefits Program eligibility criteria and agree to abide by all participation requirements. I certify that all family members listed meet the eligibility requirement of the program and that the information I have provided on this form is complete and accurate to the best of my knowledge. I understand that intentionally giving incorrect information is considered perjury and punishable to the fullest extent of the law. I understand that the health plan and its business associates have the right to use protected health information in connection with the treatment, payment and health plan operations allowed for by HIPAA.

Enrollee's Signature<sup>1</sup> \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

<sup>1</sup>Family members are not authorized to sign this form. It must be signed by the Retiree, Survivor or LTD Participant.

## Part F. To Waive Or Cancel State Coverage

### RETIREEES AND/OR SURVIVORS

Name \_\_\_\_\_ Effective Date or Terminate Date \_\_\_\_\_  
(First) (M.I.) (Last) (MM/DD/YYYY)

Social Security Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

### WAIVE COVERAGE

- ☐ **I am a retiree and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent qualifying mid-year event, I will be eligible to apply for retiree coverage only within 31 days of that event.

Spouse's Name \_\_\_\_\_ Spouse's Social Security Number \_\_\_\_\_

### CANCEL/DECLINE COVERAGE

- ☐ **I am a new retiree\* and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll except as allowed in **WAIVE COVERAGE** section.  
*\*Includes retirees ending their 12-month severance/transitional benefit period.*
- ☐ **I am a current retiree/survivor and wish to cancel my coverage in the State Health Benefits Program for retirees.** I understand that neither I nor my family members will be permitted to re-enroll in the program at any time. This serves as my written notification and authorization to cancel my coverage and that of my covered family members. This will be effective the first of the month after notice is received.
- ☐ **I am a retiree or survivor who has become eligible for coverage in an active state plan and I wish to cancel my retiree coverage.** I understand that I may re-enroll in the retiree program within 31 days of the loss of active coverage and that I must have maintained continuous coverage in the State program to do so unless I become newly eligible for retiree coverage.

If you are entitled to a Health Insurance Credit, waiving or canceling State coverage in no way affects your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### NEW VSDP/LTD PARTICIPANTS

Name \_\_\_\_\_ Effective Date \_\_\_\_\_  
(First) (M.I.) (Last)

Social Security Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

### WAIVE COVERAGE AT START OF LTD (For waiver or cancellation of existing LTD coverage due to State Open Enrollment or a qualifying mid-year event, return to part A.)

- ☐ **I am a new VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll unless I experience a qualifying mid-year event or Open Enrollment. (Open Enrollment is available to non-Medicare participants only).
- ☐ **I am a VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent qualifying mid-year event, I will be eligible to apply for retiree group coverage only within 31 days of that event.

Spouse's Name \_\_\_\_\_ Spouse's Social Security Number \_\_\_\_\_

If you are entitled to a Health Insurance Credit, waiving or canceling coverage does not affect your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If You Are Using This Form To . . .	Complete Part(s) . . .
• Enroll in plan that coordinates with Medicare	A, B, C, E
• Enroll in Non-Medicare State plan	A, B, D, E
• Enroll in <i>combination</i> of plans above	A, B, C, D, E
• Change plans and/or type of membership	A, B, C and/or D, E
• Make an Open Enrollment change (non-Medicare participant only)	A, B, D, E
• Waive or cancel participation in the State Health Benefits Program	F
• Waive existing coverage in VSDP/LTD due to open enrollment or a qualifying mid-year event, or cancel VSDP/LTD coverage	A, E
• Enroll in Extended Coverage/COBRA	Use your Election Form, part of your Election Notice.
• Change your address	A, E

  

If You Are A...	Send Completed Form To . . .
• New Retiree or New Survivor of Active State Employee • New VSDP or other LTD Participant	The Employing Agency's Benefits Administrator
• Current VRS Retiree or Survivor* • Current VSDP/LTD Participant*	Virginia Retirement System P.O. Box 2500 • Richmond, VA 23218-2500
• All Other Retirees, Survivors, or LTD Participants (Optional Retirement Plan, Local Retiree, etc.)	Your former Agency's Benefits Administrator

\* Including family members who have separate plans from the Enrollee

Agency Approval/Agency Use Only
<p>I understand that the agency Benefits Administrator is responsible for the initial setup of the retiree's, active survivor's or VSDP/LTD participant's record in the Benefits Eligibility System (BES). The agency Benefits Administrator is also responsible for forwarding a copy of the completed enrollment form to the retiree group Benefits Administrator (e.g., VRS).</p> <p>Agency Name _____ Agency Number _____ Coverage Effective Date _____</p> <p>I have reviewed this form, and verified that the retiree, survivor or LTD participant is eligible for the plan or waiver selected. I certify that the information on this form is complete and accurate to the best of my knowledge.</p> <p>Agency Representative's Signature _____ Date _____</p> <p>Print Name and Title _____ Phone Number _____</p> <p><b>This participant is enrolling as:</b></p> <p><input type="checkbox"/> Virginia Retirement System Retiree/Survivor    <input type="checkbox"/> Local Retiree/Survivor</p> <p><input type="checkbox"/> ORP Retiree/Survivor (name of ORP Vendor) _____</p> <p><input type="checkbox"/> VSDP/LTD Participant    <input type="checkbox"/> Other LTD Participant    <input type="checkbox"/> Non-Annuitant Survivor</p> <p>The participant has been told that the first premium would be in the amount of \$ _____</p> <p>If retiring, indicate type of retirement:    <input type="checkbox"/> Service Retirement    <input type="checkbox"/> Disability Retirement    Retirement Date: _____</p>

VRS Use Only (For Existing Retiree Group Members)
<p>Date Form Received _____ Effective Date of Change (subject to DHRM approval) _____</p> <p><b>For Disability Retirees:</b></p> <p>Date of Approval Letter _____ Date of Retirement _____</p>

## 2017-18 Language Assistance Statement

The Commonwealth of Virginia's State and Local Health Benefits Programs (the "Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Nondiscrimination Notice lists the services available and how to file a complaint if you feel that the Health Plan has failed to provide these services or discriminated in another way.

ATTENTION: If you need help in the language you speak, language assistance services are available to you free of charge. Send your request for language assistance to [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov) or fax to 804-786-0356.

### Spanish:

ATENCIÓN: Si necesita ayuda en el idioma que habla, servicios de asistencia lingüística están a su disposición de forma gratuita. Envíe su solicitud de asistencia lenguaje para [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov) o por fax al 804-786-0356.

### Korean:

주의 : 당신이 말하는 언어로 도움이 필요한 경우, 언어 지원 서비스를 무료로 당신에게 사용할 수 있습니다. 804-786-0356에 언어 [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov)하는 지원이나 팩스에 대한 요청을 보냅니다.

### Vietnamese:

Chú ý: Nếu bạn cần giúp đỡ trong ngôn ngữ bạn nói, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn miễn phí. Gửi yêu cầu để được hỗ trợ ngôn ngữ để [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov) hoặc fax 804-786-0356.

### Chinese:

注意：如果你需要在你講的語言幫助，語言協助服務提供給您免費。[發送您的語言協助appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov)或傳真至804-786-0356請求。

### Arabic:

لوصحل بلط لاسرا. ان اجم ةي وغلل ادعاسملا تامدخ كل رفوتت ،ملكتي يتل اةغلل ايف ددعاسم ىل اةجاحب تنك اذ: هي بنت ىلع 804 - 786 - 0356 ىل اسكافلا و [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov) ىل اةغلل ادعاسملا .

### Persian:

لاسرا. دشاب ىم ناگي ار دنتسه امش سرتسد رد نابز كمك تامدخ ،دندنك ىم تبجحص امش نابز رد كمك هب زايين امش رگا: هجوت 804 - 786 - 0356 هب سكف اي [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov) نابز هب كمك يارب ار دوخ تس اوخرد .

### Amharic:

አዳምጥ: አገተ የሚናገሩት ቋንቋ እርዳታ የሚፈልጉ ከሆነ, የቋንቋ እርዳታ አገልግሎቶች ከክፍያ ነፃ ለእርስዎ የሚገኙ ናቸው. 804-786-0356 ቋንቋ [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov) እርዳታ ወይም በፋክስ ጥያቄዎን ይላኩ.

### Urdu:

رگا پآ نا بزى م ددم را كرد ے، و ت نا بزى ك ددم ى ك تامدخ تف م ے ك چراچ نا پآ و ك : پآ رگا: مچوت مچوت و ك ددم اى سا ے ك ے ل پآ [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov) س ك ى ف 804-786-0356 نا بزى . باى ت س دى ے ى ك تس اوخرد ى جى هب .

### French:

ATTENTION: Si vous avez besoin d'aide dans la langue que vous parlez, les services d'assistance linguistique sont à votre disposition gratuitement. Envoyez votre demande d'assistance linguistique pour [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov) ou par télécopieur au 804-786-0356.

### Russian:

ВНИМАНИЕ: Если вам нужна помощь на языке вы говорите, переводческие услуги доступны бесплатно. Отправьте запрос о помощи языка к [appeals@dhrm.virginia.gov](mailto:appeals@dhrm.virginia.gov) или по факсу 804-786-0356.

**Hindi:**

ध्यान दें: आप भाषा बोलते हैं आप में मदद की जरूरत है, भाषा सहायता सेवाओं के प्रभार से मुक्त आप के ललए उपलब्ध हैं।  
 appeals@dhrm.virginia.gov~~V करने के ललए या फैक्स भाषा सहायता 804-786-0356 करने के ललए आपके अनुरोध भेजें।

**German:**

ACHTUNG: Wenn Sie in der Sprache sprechen Sie Hilfe benötigen, die Sprache Hilfeleistungen zur Verfügung stehen Ihnen kostenlos zur Verfügung. Senden Sie Ihre Anfrage für sprachliche Unterstützung zu  
 appeals@dhrm.virginia.gov~~V oder Fax an 804-786-0356.

**Bengali:**

দৃষ্টি আকর্ষণ: আপস্টি ভার্া আপস্টি কথা বলতে সাহায্য প্রত াজি হ , োহতল ভার্া সহা ো সসবা ষ্টিখরচা আপির জিয় উপলব্ধ.  
 appeals@dhrm.virginia.gov~~V অথবা ফ্যাক্স ভার্া সহা ো 804-786-0356 করার জিয় আপির অিতরাধ পাঠাি.

**Bassa:**

Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̩ [Bàsɔ̀̀- wùdù-po-nyò] jũ ní, nií, à wuɖu kà kò dò po-poòbèin m̩  
 gbo kpáa. Ðá 804-786-0353.

**Igo (Igbo):**

Ntị: Ọ bụrụ na ị chọrọ enyemaka na asụsụ ị na-asụ, asụsụ aka ọrụ dị ka ị n'efu. Send gị arịrịọ maka asụsụ aka  
 appeals@dhrm.virginia.gov~~V ma ọ bụ faksị ka 804-786-0356.

**Yoruba:**

Akiyesi: Ti o ba nilo iranlowo ninu ede ti o sọrọ, ede iranlowo isẹ ni o wa wa si o free ti idiyele. Fi ibèèrè rẹ fun ede  
 iranlowo to appeals@dhrm.virginia.gov tabi Faksi to 804-786-0356.

**Filipino(Tagalog):**

Pansin: Kung kailangan mo ng tulong sa wikang nagsasalita ka, serbisyo ng tulong sa wika ay magagamit sa iyo nang  
 walang bayad. Ipadala ang iyong kahilingan para sa tulong sa wika upang appeals@dhrm.virginia.gov~~V o fax sa 804-  
 786-0356.